DMV
A Public Service Agency

REPORT OF VISION EXAMINATION

~~(Form valid for 6 months from examination date)~~

962

APPLICANT COMPLETES THIS SECTION

DRIVER LICENSE NUMBER	DATE OF BIRTH (MO., DAY, YR.)	HOME TELEPHONE NUMBER

NAME (FIRST, MIDDLE, LAST)

RESIDENCE ADDRESS	CITY	STATE	ZIP CODE

~~APPLICATION DATE~~	~~FIELD OFFICE~~

I authorize the vision specialist conducting this examination to provide the Department of Motor Vehicles (DMV) with the following information for its confidential use (CVC1808.5) in evaluating my ability to safely operate a motor vehicle.

APPLICANT'S SIGNATURE	DATE

OPHTHALMOLOGIST OR OPTOMETRIST COMPLETES THIS SECTION

1. REFRACTION

HAVE NEW DISTANCE LENSES BEEN PRESCRIBED AND FITTED?
☐ Yes ☐ No If yes: ☐ Glasses ☐ Contact Lenses ☐ ~~Bioptic Telescope~~

DATE NEW LENSES WERE PRESCRIBED

~~IF DISTANCE LENSES WERE PRESCRIBED AND FITTED, IS THIS THE BEST POSSIBLE CORRECTION? IF NO, EXPLAIN.~~
☐ ~~Yes~~ ☐ ~~No~~

~~IF A BIOPTIC TELESCOPIC LENS WAS PRESCRIBED, IS IT~~
☐ ~~Galilean~~ ☐ ~~Keplerian~~ ☐ ~~Periscope/Keplerian~~ ☐ ~~Other~~ _____

DID YOUR PATIENT RECEIVE TRAINING IN USING THE BIOPTIC TELESCOPIC LENS?
☐ Yes ☐ No

IF YES, WAS DRIVING INCLUDED IN THE TRAINING?
☐ Yes ☐ No

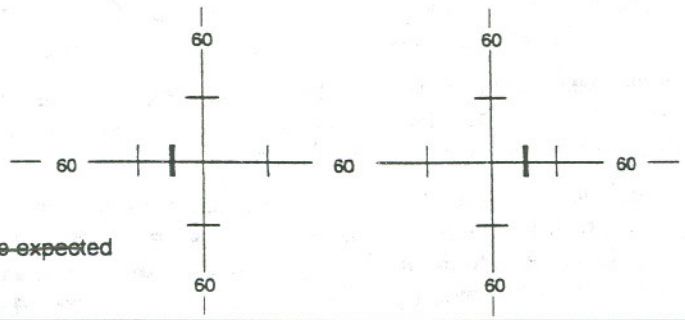
2. VISUAL ACUITY

DMV MEASUREMENT (ORTHORATER OR EQUIVALENT)				CLINICAL MEASUREMENT			
	Both Eyes	Right Eye	Left Eye		Both Eyes	Right Eye	Left Eye
Without Lenses	~~T/~~	~~T/~~	~~T/~~	Without Lenses	20/	20/	20/
With Lenses	~~T/~~	~~T/~~	~~T/~~	With Correction	20/	20/	20/

3. **VISUAL FIELDS** A full visual field examination extending at least 60°, using a standard test object such as a 10mm white mark, must be performed if any condition exists which might affect peripheral vision. Show the approximate peripheral extent and any scotomas in the diagram below.

LEFT EYE

Extent:
Left _____
Right _____
Up _____
Down _____



RIGHT EYE

Extent:
_____ Left
_____ Right
_____ Up
_____ Down

☐ ~~No condition exists that would be expected to impair visual fields.~~
☐ ~~Diagram is attached.~~

4. **DIAGNOSIS** Please indicate ~~the severity of the~~ vision condition by ~~placing a number 1, 2, or 3 in the~~ box representing the affected eye(s) ~~(1 = mild, 2 = moderate, 3 = severe). Definitions of mild, moderate, and severe, for each condition can be obtained from DMV. If your patient has Hemianopia or Pseudophakia, check the box representing the affected eye.~~

	R	L		R	L		R	L		R	L		R	L		R	L
Amblyopia	☐	☐	Aphakia	☐	☐	Astigmatism	☐	☐	Cataract	☐	☐	Diplopia	☐	☐	Glaucoma	☐	☐
Hyperopia	☐	☐	Hemianopia*	☐	☐	Keratoconus	☐	☐	Myopia	☐	☐	Nystagmus	☐	☐	Pseudophakia	☐	☐
Scotoma	☐	☐	Decreased Peripheral Vision	☐	☐	Diabetic Retinopathy	☐	☐	Macular Degeneration	☐	☐	Retinal Detachment	☐	☐	Strabismus	☐	☐
Retinitis Pigmentosa	☐	☐															
Monocular	☐	☐															
Other	☐	☐															

Could the condition in the blind eye affect the fellow eye in the future? ☐ Yes ☐ No

When was the monocular vision diagnosed? _____

*Hemianopia: Please identify the quadrants affected on the chart above.

5. PROGNOSIS

☐ ~~Stable~~ ☐ Potentially progressive ☐ Improvement possible

PLEASE ESTIMATE HOW SOON YOUR PATIENT'S VISION SHOULD BE REEVALUATED.
☐ ~~6 mos.~~ ☐ 1 year ☐ 2 years ☐ ~~4 years~~ ☐ Other _____

6. ADVICE

WHAT ADVICE HAVE YOU GIVEN YOUR PATIENT ABOUT DRIVING?
☐ ~~Drive in familiar areas only~~ ☐ ~~No night driving~~ ☐ ~~Do not drive~~ ☐ ~~No advice given~~ ☐ ~~Other~~ _____

PRINTED NAME	SIGNATURE	M.D. OR O.D. LICENSE NUMBER	DATE OF EXAM
	X		

ADDRESS	CITY	ZIP CODE	TELEPHONE NUMBER
			( )

DIRECTIONS FOR COMPLETING THIS FORM

The information below will assist the applicant and opthalmologist or optometrist (eye doctor) in completing the front of this form. Accurate information is important and necessary in determining the patient's/applicant's visual ability for driving.

APPLICANT'S SECTION

Please complete the driver license number, date of birth, telephone number, name and address areas of this form. The application date is the date you received this form from DMV. The field office is the DMV office from which you received this form. Enter the name of the city in which the office is located. **You must sign and date the authorization line.** This allows your eye doctor to provide DMV with information about your vision. All medical information received by DMV is confidential under California Vehicle Code Section 1808.5. Please bring the completed form with you when you return to DMV for further testing. **DO NOT MAIL THIS FORM BACK TO DMV** unless asked to do so by a DMV employee. Alterations or erased information will void this form.

Your vision specialist is expected to conduct a full vision examination. Information from your vision records more than 6 months old should not be reported on this form.

OPTHALMOLOGIST'S OR OPTOMETRIST'S (EYE DOCTOR) SECTION

The remainder of the form will be completed by an eye doctor. The form has been designed so most of the information can be provided quickly by checking the appropriate boxes. If you wish to provide additional information, please attach additional sheets.

1. **REFRACTION:** Please check "yes" or "no." If "yes," check the type of lenses you have prescribed for your patient and the date of the prescription. Record "yes" or "no" if new lenses are the best possible correction. If "no," please explain.

2. **VISUAL ACUITY:** Your patient's vision has already been tested in one of DMV's field offices. An Ortho-Rater, Optec 1000, or Titmus device was used to measure visual acuity. The target scores are recorded in the box "DMV Measurement." Below, for your information, are the Snellen Chart equivalents for the targets.

Target 1 = 20/200	Target 4 = 20/50
Target 2 = 20/100	Target 5 = 20/40
Target 3 = 20/67	Target 6 = 20/33

   Please enter your patient's visual acuity reading in the box "Clinical Measurement." All appropriate spaces under this heading must be filled in by the eye doctor. Lenses include both contact lenses or glasses.

3. **VISUAL FIELDS:** If any condition exists which may affect peripheral vision, please perform a full visual field examination extending at least 60°, using a standard test object such as a 10mm white mark. Measure and record both nasal and temporal fields for each eye. Please show scotomas on the diagram.

4. **DIAGNOSIS:** Various vision conditions are listed with a box to indicate the severity of the condition. 1 represents a mild condition, 2 represents a moderate condition, and 3 represents a severe condition. Check the box which indicates your patient's vision condition. If the diagnosed condition is not listed, write the diagnosis under "other." Indicate if the left, right, or both eyes are affected by the vision condition by placing an "L," "R," or "B" on the line following the condition.

5. **PROGNOSIS:** Mark either "Stable," "Potentially Progressive," or "Improvement possible." Please note if your patient has multiple conditions and some are stable while others are progressive. For unstable conditions, please recommend when a reexamination by DMV is advisable.

6. **ADVICE:** Indicate if you have counseled your patient concerning visual field loss and any advice you may have given your patient regarding driving.

COMMENTS: Report any additional information or comments you feel DMV should know concerning your patient's visual and perceptual capabilities relating to driving performance. Use an additional sheet of paper to provide this information as well as existing conditions exist which contribute to poor night vision or poor depth perception. Also note if you have given your patient advice regarding driving. Any recommendations about the patient's general safety should also be made. ***DMV will make the final licensing decision based on your professional expertise and other information DMV has on your patient.***

SIGNATURE: Your signature and address are necessary to validate this report. Please include your physician or optometrist license number.

Return the completed form to your patient. Your patient is responsible for returning this form to DMV.